

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION

REGIONAL COMMUNITY SERVICES
COMPREHENSIVE MORTALITY REVIEW

DEMOGRAPHIC DATA

Consumer #: _____ Sex: _____ Case #: _____ Region#: _____

Fname: _____ Lname: _____ SS: _____

Site Address and Admission Date: _____

Residential Opr: _____ Res Site Code: _____ 310: _____

Contact Relationship/Agency: _____ Contact Phone: _____

Prog/Loc. Opr.: _____ Loc. Site Code: _____ 310: _____

Date of Birth: _____ Age at Death: _____ Cause: _____

HEALTH INFORMATION—Only needed if death was the result of long term medical
condition or medical emergency

Health History for the Past Five Years:

Medications at Time of Death:

_____	_____
_____	_____
_____	_____
_____	_____

Treatment History Related to Condition or Medical Emergency (include name of physician):

CIRCUMSTANCES OF DEATH

Summary—Discuss events immediately prior, response to emergency, medical treatment received, autopsy findings if applicable:

RECOMMENDATIONS/QUALITY ENHANCEMENT ACTIONS

Signature of Person Completing Report

Date

Reviewed by (RCS Staff)

Date